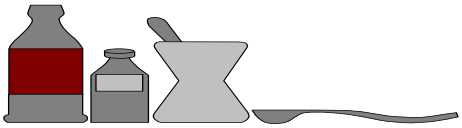

MEDI-CAL DRUG USE REVIEW BOARD
MEETING MINUTES
Tuesday, September 13, 2005
10:00 a.m. to Noon

Location: Department of Health Services
1501 Capitol Avenue, Room 71.4003
Sacramento, CA 95814

Topic	Discussion
1) CALL TO ORDER	Meeting was called to order by Dr. McBride Members present in person: Janeen McBride, Kenneth Schell, Andrew Wong, Ross Miller, Patrick Finley, Marilyn Stebbins, Robert Mowers Members present by conference call: Stephen Stahl Members absent: Craig Jones, Tim Albertson
2) APPROVAL OF LAST MINUTES	Dr. McBride moved to approve the minutes from the May 10, 2005 Board meeting. Dr. Schell seconded the motion. Minutes unanimously approved.
3) DEPARTMENT OF HEALTH SERVICES (DHS) COMMENTS	A. Roles and Responsibilities of the Drug Use Review (DUR) Board 1. OBRA '90 set forth the initial federal code requiring states to implement DUR programs. 2. Federal Code of Regulations (42CFR456.700) provides guidance and describes the requirements for each state's DUR program. 3. There is no state law or regulation to guide the DUR program. The Medi-Cal DUR Board's activities are guided by a set of Bylaws that are currently under revision to reflect the current and future activities of the Board. In general, DHS seeks to adopt a more data-driven approach to drive policy and quality improvement. B. Coordination of DUR activities with other DHS services 1. California Health Improvement Projects (CHIPs) is the umbrella term for projects that resemble "disease management". Medi-Cal Pharmacy Policy has drafted a set of standards for CHIPs. The Medi-Cal Advisory Committee (MCDAC), the DUR Board, and the current CalMEND program have some overlapping activities and responsibilities for meeting these standards. Dr. Mowers discussed a process proposed by the California Healthcare Foundation and UC Davis Health as an example of how a disease state or therapeutic class review can coordinate with individual drug reviews. Drug reviews can focus on specific questions around a disease state or principal treatment pathways. Key issues or variations from "best practice" can be addressed by the DUR Board and considered by the MCDAC in reviewing a drug that has been petitioned for addition to the Medi-Cal Contract Drug List. Dr. Miller is currently the only common member between the MCDAC and the DUR Board. 2. Medicare Modernization Act (MMA). All full-scope dual eligible Medi-Cal beneficiaries will be automatically enrolled into a Part D drug plan for coverage of drugs beginning January 1, 2006. Although Medi-Cal will lose the responsibility for the drug benefit of these dual eligibles, Medi-Cal is still responsible for paying the bill and conducting DUR on the claims adjudicated by the Medicare Prescription Drug Plans (PDPs). Medi-Cal is in discussion with the potential PDPs to arrange for information exchange. The issue of prospective DUR is more troublesome since Medi-Cal is not adjudicating claims. Medi-Cal has consulted the Centers for Medicare and Medicaid Services (CMS) regarding whether or not Medi-Cal is still required to perform prospective DUR on Medicare claims. One of the issues that Medi-Cal is facing is the risk of Medicare beneficiaries who may simply "check themselves in" to long-term care (LTC) facilities because they cannot figure out how their new drug benefit works. This is of concern to Medi-Cal since LTC is costly to the State. The Department is currently working on a project with CPhA and USC School of Pharmacy to identify elderly patients at risk for institutionalization. The DUR Board is welcome to participate on this project.

4) CALIFORNIA MENTAL HEALTH DISEASE MANAGEMENT (CalMEND)	Dr. Handon, Department of Health Services, provided an update on the progress made on the CalMEND project since last reported in February 2005. The Oversight Committee is currently being represented by stakeholders in the care of patients with mental health. A new subcommittee is being formed which includes client and family members of the mental health system. An update for each of the subcommittees was provided: 1. Practice Management Subcommittee: Currently revising the manual used by the Texas program to reflect California's strategy. A section on Medication Adherence will be added. The results of the CATIE trial will be taken into consideration after its publication. Dr. Stahl expressed concern that medication algorithm decisions would be based primarily on costs. 2. Data and Performance Measurement Subcommittee—lead by Dr. Cecil Lynch of the UC Davis Medical Informatics program. The committee is coordinating its thinking with the Outcomes and Performance Committees responsible to the Mental Health Services Act (MHSA). Dr. Lynch has just completed a data mapping exercise to assist the subcommittee in identifying necessary data elements to capture. 3. Reimbursement Subcommittee—CalMEND intends to form a committee to address the issues of reimbursement for mental health services to include ancillary healthcare professionals. Mental Health Services Act (Proposition 63) Funding—the Pharmacy Policy Section has applied for a significant amount of funding from the Proposition 63 dollars.
5) UTILIZATION REPORTS	A. Quarterly Reports for DUR Board review: DHS presented a draft of a quarterly report format for the Board to review and revise. The following revisions were requested: 1. Prospective alerts per claim be presented in table format, i.e. the number of claims receiving 2 ,3,4,5, etc. alerts. 2. Generic vs. Brand utilization 3. In general, more commentary to explain trends or variations. 4. Atypical antipsychotics be grouped into one therapeutic class category. B. Non-Steroidal Anti-Inflammatory (NSAIDs) trend analysis: The overall utilization of this category has declined by 19% since the first COX-2 was removed from the market in the fourth quarter of 2004. With a shift from the COX-2 agents to the older NSAIDs (primarily Mobic and Motrin), the total amount paid by Medi-Cal over the past year dropped by 43%. C. Proton Pump Inhibitor Post-Therapeutic Class Review (TCR) Impact Analysis This report was provided as an example of ongoing measuring of impact following a TCR. What we hope to see is a shift towards utilization of covered agents.
6) DRUG-AGE PRECAUTION (PA) ALERT	An analysis of the appropriateness of the drug-age precaution alert was conducted using data from March 2005. This alert is intended to warn the pharmacist when a precaution exists for the drug being dispensed. The alerts are sent based on the age of the recipient on the date of service and should apply rules based on two age categories: age $\leq$ 18 years (pediatric) or age $\geq$ 65 years (geriatric). The pediatric category is further sub-categorized by specific age ranges, e.g. 0 – 6 years. The current prospective DUR system sends a PA alert for drugs with pediatric or geriatric precautions for all patients < 18 years or > 65 years regardless of the intended age precaution. For example, if there is an imipramine claim for a 68 year old (and the intended age range of the alert is 0-6 years old), then the claim still generates the PA Alert. The PA alerts that were sent in March 2005 were intended for pediatric patients under 18 years of age. The actual age distribution, based on age at the date of service, showed that all but a handful of beneficiaries were older than 65 years old. The Board voted to keep the PA alert active based on the possibility that at least one of the alerts will be applied appropriately to prevent an adverse effect. The Board also requested that EDS report back to the Board the feasibility of fixing the alert to send alerts appropriately.

7) USE OF APPROPRIATE MEDICATIONS IN PATIENTS WITH ASTHMA	Based on the large number of Early Refill alerts received on albuterol, DHS seeks to conduct an evaluation of the appropriate use of medications in Medi-Cal FFS beneficiaries with asthma. The study will use the established HEDIS measures and the required DHS Managed Care 2005 measure for overuse of beta agonist therapies. After establishing a benchmark using validated measures, DHS wishes to expand the study to include additional measures of utilization and outcomes. Dr. Miller suggested that the classification follow the National Heart, Lung, and Blood Institute (NHLBI) guidelines for mild, moderate and severe persistent asthma. One of the limitations of using administrative data is that clinical data (such as symptoms or pulmonary function test results) are not collected and, therefore, a more clinical classification is not feasible. Dr. Albertson has volunteered to take the lead on this study.
8) CHRONIC OPIOID MEDICATION USE EVALUATION	A one-year follow-up study using the Chronic Opioid Medication Evaluation tool was presented to the Board. Over the past year, DHS has seen an increase in the volume of claims for both short-acting (SA) and long-acting (LA) opioids. There has been a decrease by 50% in the number of beneficiaries receiving prescriptions from 4 or more prescribers. This may be due in large part to the increased requirement for pharmacies to report claims information on all Schedule II-III drugs to CURES. There were no other significant changes from the baseline report. The Board suggested that DHS continue to monitor the number of patients receiving four or more grams of acetaminophen per day. Of the patients receiving high doses, the Department should track the number of patients with liver or kidney disease.
9) PUBLIC OR DUR BOARD COMMENTS	None
DATE OF NEXT DUR BOARD MEETING	Tentatively on November 8, 2005.
ADJOURNMENT	The meeting adjourned at 12:00 PM

Summary of Action Items:

1. **Board members are encouraged to volunteer to work on any of the following projects:**
   - **CalMEND subcommittees**
   - **Appropriate Use of Medications in Patients with Asthma**
   - **Prevention of Institutional Placement Due to Medication-Related Problems Among Vulnerable Community-Dwelling Elderly.**

   Please contact Lisa Ashton to express your interest.
2. **Quarterly Reports revisions as suggested above.**
3. **Tylenol Toxicity Monitoring**